

**ASSESSMENT OF
USAID'S POPULATION ASSISTANCE
PROGRAM IN TURKEY**

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TABLE OF CONTENTS

LIST OF ABBREVIATIONS	v	
MAP OF TURKEY.....	vii	
EXECUTIVE SUMMARY.....	ix	
LIST OF RECOMMENDATIONS.....	xiii	
1. INTRODUCTION.....	1	
1.1 Background	1	
1.1.1 Population, Family Planning, and Fertility in Turkey.....	1	
1.1.2 The Current Situation.....	1	
1.2 USAID's Strategy for Population Assistance to Turkey	2	
1.3 Assessment Scope of Work	3	
1.4 Methodology	4	
1.4.1 Schedule and Approach	4	
1.4.2 Analytical Framework.....	5	
2. PROGRAM ACHIEVEMENTS.....	7	
2.1 Goal Achievement: Health, Fertility, and Population Growth.....	7	2.2
2.2.1 Policy Support for the Family Planning Program	7	
2.2.2 Access to Family Planning Services and Contraceptives	8	
2.2.3 Quality of Family Planning and Reproductive Health Services, Training, and Information, Education, and Communication	9	
3. COOPERATING AGENCY PERFORMANCE	13	
3.1 Introduction.....	13	
3.2 The POLICY Project.....	14	
3.2.1 National Plan.....	14	
3.2.2 Contraceptive Self-Reliance	15	
3.2.3 Market Segmentation	16	
3.2.4 Strategic Planning	18	
3.2.5 NGO Network.....	18	
3.3 Social Marketing for Change	19	

3.3.1	KAPS: The Provider Network	20
3.3.2	Health Insurance	23
3.3.3	Private Sector Contraceptives	24
3.3.4	Improvements in Quality of Services and Information	25
3.4	Family Planning Management Development.....	26
3.4.1	Program Statistics (Management Information System)	27
3.4.2	Contraceptive Logistics.....	28
3.4.3	Data for Decision Making.....	28
3.4.4	NGO Support	29
3.5	Johns Hopkins University Population Communication Services	30
3.5.1	General Comments on Information, Education, and Communication Materials	
3.5.2	Develop Information, Education, and Communication National Strategy and Implementation Plan	30
3.5.3	Develop, Monitor, and Evaluate KAYNAK Family Planning Package	31
3.5.4	Coordinate Information, Education, and Communication Activities	31
3.5.5	Produce and Distribute IEC Provider Materials in Coordination with Hacettepe Institute of Population Studies (HIPS)/AVSC and SOMARC.....	33
3.5.6	Produce and Distribute Client-Oriented IEC Materials	33
3.5.7	Future Activities.....	33
3.6	AVSC International.....	34
3.6.1	Introduction of New Contraceptive Methods.....	35
3.6.2	Training in Voluntary Sterilization—Minilap and No-Scalpel Vasectomy.....	37
3.6.3	Expansion of Postabortion and Postpartum Contraceptive Services	37
3.6.4	Develop Quality Services through Method Choice, Skilled Providers, and Informed Choice for Clients	38
3.6.5	Identification and Alleviation of Medical Barriers that Limit Access to Family Planning Services.....	38
3.6.6	Increase Availability of Quality Family Planning Services to Underserved Groups in Major Metropolitan Areas and the Southeast	39
3.7	Johns Hopkins Program for International Education in Reproductive	

Health	41
3.7.1 Development of National Family Planning Service Guidelines	41
3.7.2 Strengthen Family Planning and Reproductive Health Pre-service Medical Training.....	42
3.7.3 Strengthen Family Planning and Reproductive Health Pre-service Midwifery Training.....	44
3.7.4 Strengthen the Family Planning and Reproductive Health In-service Training System	45
4. MANAGEMENT AND COORDINATION.....	47
4.1 Program Management and Coordination	47
4.2 Donor Coordination	48
5. FUTURE NEEDS AND DIRECTIONS	49
5.1 An Integrated Postabortion and Postpartum Initiative	49
5.1.1 Goals of the Initiative.....	49
5.1.2 The Problem.....	49
5.1.3 Specific Objectives	52
5.1.4 Design Elements	52
5.1.5 Illustrative Roles of CAs.....	52
5.1.6 Resources	53
5.2 Completion of Country Strategy Activities (1997 to 1999).....	53
5.3 Future Assistance Options, Beyond the Year 2000	55
5.3.1 High-Priority Actions.....	55
5.3.2 Medium-Priority Actions	56
5.4 Summary and Conclusions.....	56

APPENDICES

Statement of Work	A-1
Bibliography.....	B-1
List of Contacts	C-1
Turkey Population Assistance and Goals.....	D-1
SOMARC KAPS Activities	E-1
Illustrative Model of Preservice Training of Medical Students: Inputs and Outputs.....	F-1

LIST OF ABBREVIATIONS

AVSC	AVSC International
CA	Cooperating Agency
CBD	Community-based distribution
CEDPA	Centre for Development and Population Activities
CTU	Contraceptive technology update
CuT	Copper T (IUD)
DDM	Data for Decision Making project
DHS	Demographic and Health Survey
DMPA	Depo-Provera
ENI	Bureau for Europe and the New Independent States (USAID)
EU	European Union
FP	Family planning
FPLM	Family Planning Logistics Management project
FPMD	Family Planning Management Development project
FPSD	Family Planning Service Delivery
FY	Fiscal year
GTZ	German Technical Cooperation
GD	General Director(ate)
GOT	Government of Turkey
GP	General practitioner
HIPS	Hacettepe Institute of Population Studies
HPHF	Hacettepe Public Health Foundation
HRDF	Human Resource Development Foundation
ICPD	International Conference on Population and Development
IEC	Information, education, and communication
IPS	International Population Services
IUD	Intrauterine device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU	Johns Hopkins University
JICA	Japan International Cooperation Agency
JPT	Joint Programming Team
JSI	John Snow, Inc.
KAPS	Women's Health and Family Planning Service System
KAYNAK	A high-quality family planning counseling training kit for providers
KIDOG	Kadin Icin Destek Olustruma Grubu (NGO Advocacy Network for Women)
LAH	Long-acting hormonal
LMIS	Logistics management information system
LOE	Level of effort

MIS	Management information system
MOH	Ministry of Health
MR	Menstrual regulation
MSH	Management Sciences for Health
NFPSG	National Family Planning Service Guidelines
NGO	Non-governmental organization
NORPLANT®	Contraceptive method
NSV	No-scalpel vasectomy
NWH/FP	National Women's Health and Family Planning Strategy
OB/GYN	Obstetrics/gynecology
PA/PP	Postabortion/postpartum
PCS	Population Communication Services project
POLICY	Policy Analysis, Planning, and Action project
POPTECH	Population Technical Assistance Project
PQA	Population quality assessment
QOC	Quality of care
RH	Reproductive health
SEATS	Family Planning Services Expansion and Technical Support
SOMARC	Social Marketing for Change
SOW	Scope of Work
SSK	Sosyal Sigortalar Kurumi (Social Security Institution)
STD	Sexually transmitted disease
TDHS	Turkish Demographic and Health Survey
TFHPF	Turkish Family Health & Planning Foundation
TL	Tubal ligation
TQM	Total quality management
Turk-Is	Turkish labor union
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VDO	Video
VS	Voluntary sterilization
WRA	Women of reproductive age
ZTB	Zekai Tahir Burak (Maternity Hospital)

MAP OF TURKEY

Available in hard copy only

EXECUTIVE SUMMARY

The United States Agency for International Development (USAID) has supported population and family planning (FP) activities in Turkey since the mission closed in 1975. A phase-down strategy is under way for the period from 1995 to 1999, with funding beyond that period uncertain. A four-person team conducted a five-week project assessment to review project achievements and make recommendations for any needed midcourse corrections. The evaluation team spent the first and fifth weeks in Washington, D.C., the other three weeks were spent in Turkey. The team made site visits in Ankara, Istanbul, Adana, Diyarbakır, and Eskisehir. Individual and group meetings were held with the six Cooperating Agencies (CA) who provide the funding and technical assistance for program activities.

Program Achievements

The USAID program has two broad objectives: (1) to increase the use of modern contraceptives and (2) to increase the self-reliance of the program. The strategy is organized according to three program components: policy, quality, and access.

Policy

The program has made significant progress in its objective to increase support for family planning and reproductive health (FP/RH) within the governmental, private, and non-governmental sectors. Support from the Ministry of Health (MOH), the Social Security Institution (SSK), non-governmental organizations (NGO), and the private sector has increased. The private sector is making a major contribution to contraceptive self-reliance by introducing two new injectables and an IUD. The private sector also controls 75 percent of the oral contraceptive and condom markets. In addition, the MOH has initiated procurement of a modest supply of pills and condoms this year. However, with the possible exception of the private sector, none of the sectors have made sufficient progress in assuring self-reliance of high-quality family planning and reproductive health services. Much work remains in that area.

Quality

Project activities with regard to the quality component were concentrated on improving services and information; conducting family planning training; and developing information, education, and communication (IEC) materials for providers and clients. The program has made some progress in both the public and private sectors in such areas as provider training, infection prevention practices, counseling, and total quality management (TQM). However, provider bias is still a problem, as is client knowledge and understanding of contraceptive methods.

Improvements are still needed in counseling, supervision, and consumer awareness. Although the program has made significant improvement in clinical training, the focus has been on training a small proportion of medical school interns rather than training the midwives, obstetrician/gynecologist (OB/GYN) specialists, and others who provide family planning services. A large amount of high-quality IEC materials has been developed over the years for providers and clients, but these materials have not been widely disseminated or evaluated. The lack of a central IEC unit to coordinate and manage IEC in family planning and reproductive health is a significant constraint.

Access

The program's objectives in this component were to increase access to the following:

- Family planning and reproductive health services and contraceptives in the private and public sectors,
- Postpartum and postabortion (PA/PP) services, and
- Underserved populations.

Although the MOH and SSK have expanded services in their facilities, services are not yet universally available. Many MOH facilities do not provide services due to lack of staff, equipment, or contraceptives. Within the SSK system, family planning and reproductive health services are available in approximately 50 of the 505 facilities. Access to contraceptives has also been expanded, but is not universal. Minilaparotomy is now available in 20 provinces, Depo-Provera (DMPA) in 8 provinces. USAID has focused its efforts to expand private sector service through a network of providers in Istanbul. Currently, only 45 sites are included in this experimental provider network. But, access to private sector contraceptives will increase rapidly with the nationwide launch of two new injectables and an IUD. Furthermore, the program has introduced some postpartum and postabortion FP services with promising results. Services have been expanded in underserved urban areas and plans are being developed to target couples in the Southeast, as well as military personnel.

Cooperating Agency Performance

Chapter 3 of this report describes the roles, activities, and achievements of each of the six CAs currently working in the Turkey program. They are as follows:

- **Policy Analysis, Planning, and Action project (POLICY):** Public policy issues

- **Social Marketing for Change project (SOMARC):** Private sector involvement (contraceptives and services)
- **Family Planning Management Development project (FPMD):** Management strengthening, especially management information systems (MIS)
- **Johns Hopkins University/Population Communication Services project (JHU/PCS):** IEC materials and coordination
- **AVSC International:** Clinical services and training
- **Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO):** Clinical training

These CAs have been responsible for carrying out the individual activities that make up the program. All have made contributions that have had or have the potential for having significant impact on program objectives, although some of these activities have been fragmented, limited in geographic scope, and not sufficiently integrated to achieve the desired impact. This condition is about to change, however, because the CAs and USAID staff are revising their approach to work more closely together on a limited set of interventions.

Management and Coordination

The program management system followed in this program has been considered a model for other programs in countries without USAID missions. The model is still evolving; indications are that it already works well and is likely to work even better once the new procedures are implemented. This model deserves continued support from USAID/Washington, as well as from the headquarters of each of the CAs.

Future Needs and Directions

The team recommends that USAID and the CAs focus on developing interventions that will have a significant impact over time, that are replicable and sustainable, and that can be institutionalized. An integrated "postabortion and postpartum initiative" was proposed by the team and enthusiastically endorsed by the CAs and USAID staff. In fact, the CAs have already started to develop preliminary plans for this initiative. Additionally, a list of 18 priority activities that need to be completed over the next two years has been prepared by the team. Suggestions for future assistance are also included in case funding becomes available beyond the end date of the current strategy.

LIST OF RECOMMENDATIONS

Chapter 2

1. Over the next two years, USAID, the CAs, and Turkish counterparts in the public and private sectors need to focus on the larger picture. The key question they should be asking is, "What can we do to ensure that a lasting impact is made on family planning and reproductive health services and, in turn through those services, women's health, fertility, and population growth?"
- 20 Greater interaction and more integration of program elements is needed to achieve national impact. Workplans should include quantified, annual performance indicators at the intermediate level (e.g., suggested postabortion and postpartum intervention).
- 30 All major interventions, especially any new ones, should include sustainability strategies from the outset.
- 40 All major interventions should be designed to be replicable on as wide a scale as possible.
- 50 Performance indicators need to be quantified and expanded to include more intermediate indicators such as new acceptors and active users. Procedures need to be developed to collect, analyze, and report data on these indicators.
6. Research and evaluation are needed to assess needs (e.g., for clinical training and IEC materials) and to determine whether key interventions (e.g., clinical training and postabortion services) are having the desired impact.
- 70 An assessment of provider adherence to quality of care (QOC) practices should be included in the assessment of the Women's Health and Family Planning Service System (KAPS) activities this year.

Chapter 3

- 80 POLICY should work to ensure that the national implementation plan is finalized and realistic.
- 90 POLICY should collaborate with a service-provision CA (AVSC or JHPIEGO) to strengthen the NGO Advocacy Network for Women's (KIDOG) capacity to undertake effective advocacy actions related to family planning and reproductive health.
- 100 POLICY should continue to work with the MOH to develop and refine its strategic planning and targeting capabilities.

- 110 POLICY should continue its market segmentation activities, moving as quickly as possible to stage 2 (MOH decisions on a targeting strategy) and to stage 3 (identification of actions and development of procedures to implement the targeting strategy).
12. SOMARC should conduct a special survey to measure the impact of KAPS on the number of private providers added and clients served.
13. Rather than expand KAPS in Istanbul, SOMARC should concentrate on finding ways to make the family planning and reproductive health services in each of the 45 sites self-sustaining.
14. SOMARC should help implement the proposed postabortion and postpartum intervention in as many of KAPS's hospitals and polyclinics as possible. This intervention could also help to increase sustainability.
15. SOMARC should develop an alternative, low-cost model for Izmir only if a commercial partner can be found to ensure sustainability. Otherwise, this activity should not be pursued.
16. SOMARC should continue to lobby the insurance providers to include family planning and reproductive health services as benefits.
17. SOMARC (and/or POLICY) should provide technical advice to the Health Reform Commission to include family planning and reproductive health as a benefit, especially under any managed care programs under consideration.
18. SOMARC should be prepared to provide assistance to ensure the smooth transition of the injectable market to the private sector over the next two years.
19. SOMARC should monitor sales of commercial Copper T (CuT) 380A IUDs over the next year and be prepared to intervene with marketing advice if sales do not meet expectations.
20. SOMARC should conduct an assessment of the quality of KAPS's services.
21. FPMD should continue with plans to extend both the MIS and logistics management information system (LMIS) and should examine ways to speed up the schedule for new MOH provinces adopting the LMIS (the MOH has responsibility for actual implementation).
22. The planned Data for Decision Making (DDM) activities are an important complement to the LMIS and to the MOH's new MIS overhaul efforts. These activities should proceed.

23. FPMD should work closely with the MOH's MCH/FP General Directorate (GD) and the new MIS Department to plan the 1998 regional workshops and include in these workshops techniques and materials geared to the new MOH system, as well as to the SSK system.
24. PCS should continue to assist the MOH to expand its capacity to implement effective IEC programs.
- 250 PCS should take a leadership role in assisting the MOH to coordinate all donor IEC family planning activities in Turkey.
- 260 PCS should evaluate the use and effectiveness of the materials available before additional IEC materials are developed by CAs. PCS (with AVSC and JHPIEGO) needs to evaluate the use and effectiveness of the KAYNAK package and other IEC materials, including the Pocketbook, POP reports, DMPA materials for providers, and PA/PP materials that are to be used for new initiatives.
27. PCS should work to ensure that IEC materials are distributed and used efficiently.
28. The CA inventory should be revised periodically and expanded to include all donor materials. PCS should ensure that other donors have copies of the inventory and should provide sample materials as available.
29. The idea of a national, mass-media campaign should be dropped. Instead, attention should focus on developing a national strategy for IEC, to include extensive use of the local TV networks to reach clients and providers.
30. PCS should consider integrating postabortion and postpartum counseling skills into the International Population Services (IPS) training course.
31. PCS should contact the Turkish Family Planning Foundation (TFHPF/TAP) for information on TAP's existing family planning training before launching a new initiative for the military.
- 320 AVSC should continue to assist in training public and private health providers in DMPA, particularly emphasizing counseling for side effects, to increase public sector coverage and to promote and support the use of this method in the private sector.
33. AVSC should continue to provide assistance in expanding minilap services and training of trainers (TOT) for minilap and vasectomy. Voluntary sterilization (VS) training should be planned to provide for national coverage of services.

- 340 A PA/PP initiative should be designed incorporating a CA team effort and involving the public and private sector. This initiative should be designed with baseline data and tracking of outputs to measure progress.
35. AVSC should work with the other CAs and the MOH to develop a national plan for training and service provision to provide a higher, more consistent level of quality of nationally available family planning services.
- 360 AVSC, with the other CAs, should integrate simple data tracking into its activities to report service delivery progress and outcomes beyond training outputs.
- 370 AVSC should review its 1998 workplan to identify priority activities including assistance to SSK. Additionally, AVSC should consider phasing out those activities that are marginal to the population quality assessment (PQA) objectives and focus on expanding activities, such as postabortion and postpartum services that have the greatest potential for impact.
38. AVSC should work with the MOH and SSK to ensure that underserved areas are given priority for training and other activities designed to improve family planning service quality and access.
- 390 JHPIEGO should work closely with the MOH and SSK to ensure dissemination and use of the guidelines in all hospitals and clinics, including those in the private sector that provide FP services.
40. The MOH/JHPIEGO/Hacettepe University-Department of Public Health (DPH) should conduct a follow-up evaluation of course graduates and an assessment of physicians' family planning and reproductive health training needs. Based on the outcome of this assessment, JHPIEGO and Hacettepe University-DPH should revise the current pre-service project for medical students. Hacettepe University-DPH should play a lead role in carrying out work in this area.
41. JHPIEGO's future technical assistance should focus on strengthening pre-service midwifery training and improving the in-service training system for practicing MCH/FP personnel.
42. JHPIEGO should call upon the American College of Nurse Midwives to assist in reviewing and updating the pre- and in-service training programs for midwives.
43. JHPIEGO should examine the experiences and lessons learned in distance learning for midwives being used by the Eskisehir Anadolu University-Open University Program, including the use of local TV for self-paced learning.

44. Any in-country technical committee or advisory panel in family planning and reproductive health should be expanded to include leaders in midwifery education and training.
45. JHPIEGO should examine the potential for conducting "on-the-job training," self-paced instruction, and distance learning using local TV to increase effectiveness and efficiency.
46. The MOH, with technical assistance from JHPIEGO, should develop an in-service training plan for the next two years. A targeted approach should be developed that identifies the number and type of family planning training needed for different cadres of personnel. The plan should target practicing personnel and should include an evaluation of the impact of training at the service delivery level.

Chapter 4

47. USAID/Washington and the central headquarters of each participating CA should provide continued backup support, but should allow the management and direction of the program to be handled by the embassy staff and local CA representatives.

1. INTRODUCTION

1.1 Background

1.1.1 Population, Family Planning, and Fertility in Turkey

Turkey's family planning program is an acknowledged success story. Between 1971 and 1993 the total fertility rate (TFR) declined from 5.9 to 2.7. The contraceptive prevalence rate (CPR) rose from 38 percent in 1978 to 62.6 percent. Furthermore, knowledge of modern methods is almost universal at 99 percent.

The Government of Turkey (GOT) is very supportive of the program. It views population growth and fertility as too high and wants to lower both rates. The Ministry of Health (MOH) has a governmental unit—the Maternal and Child Health/Family Planning General Directorate (MCH/FP GD)—that is responsible for family planning services. Abortion and sterilization are available on request. The MOH and other government sectors have worked to incorporate family planning services in most hospitals, health centers and dispensaries. The Social Security Institution (SSK), which covers approximately 40 percent of Turkey's 22 million people, has expanded family planning services to more than 50 health care facilities. In addition, the private sector has become increasingly involved in providing contraceptives and services; this service has been welcomed by the GOT. Furthermore, external assistance from donor organizations has been significant and demonstrates the faith that these organizations have in the program. The United Nations Population Fund (UNFPA), the International Planned Parenthood Foundation (IPPF), the European Union (EU), the Japan International Cooperating Agency (JICA), the German Technical Cooperation (GTZ), and the United States Agency for International Development (USAID) have all made contributions to family planning activities in the public and private sectors.

1.1.2 The Current Situation

Despite past successes, much work remains. While overall contraceptive prevalence is high, only 35 percent of eligible women use modern methods (a figure lower than that of Bangladesh, for instance); 28 percent use traditional methods, especially withdrawal. An estimated five million couples of reproductive age have an unmet need for family planning. Some 70 percent of married women say they do not want any more children and an additional 14 percent wish to delay their pregnancy for at least two years. Unmet need is especially high in the East and Southeast, in slum areas, and in rural and remote areas. Abortion is widely used as a backup to contraceptive failure and unwanted pregnancy. Discontinuation rates are high, and there is significant provider bias with respect to hormonal and permanent methods. Thus, government support for family planning needs to be translated into effective programmatic action including rigorous management and adequate funding.

These important problems deserve donor attention. Encouraging policy changes and improving access to and quality of family planning services in Turkey remain important to USAID and are the priority areas for current assistance.

1.2 USAID's Strategy for Population Assistance to Turkey

USAID has been providing support to Turkey for population and family planning activities since the mission closed in 1975. Starting in 1995, USAID began a phase-down strategy for the period 1995 to 1999. Population funding was reduced from \$7.2 million in 1995 to \$5.6 million in 1996. These annual reductions will continue over the next several years, reaching an assistance level of about \$3 million to \$4 million annually by the end of the century. However, over this five-year period, USAID's broad goals remain the same: to improve women's health, lower fertility, and reduce population growth rates to levels consistent with sustainable development.

USAID's strategy, endorsed by the GOT in 1995, has two principal objectives: (1) to increase the prevalence of modern contraceptive use and (2) to promote program sustainability. Formally, the two strategic objectives are as follows:

1. To increase availability and effective use of quality family planning and reproductive health (FP/RH) services, and
2. To improve Turkey's self-reliance in family planning and reproductive health by enhancing public and private sector ability to meet consumer demand for these services without USAID support.

USAID's strategy is organized according to three program components: policy, quality, and access. The principal anticipated outcomes of these components are summarized in Table 1.

Since Turkey has no USAID mission, the program is managed by a Joint Programming Team (JPT) comprised of representatives from USAID's Bureau for Global Programs, Field Support and Research, the Bureau for Europe and the New Independent States (ENI), and the U.S. Embassy in Ankara. Day-to-day management is handled by a locally hired PHN officer and an assistant.

To implement program activities, USAID has had contractual agreements with six Cooperating Agencies (CAs), each selected because of its expertise in specific areas of technical assistance. These CAs work with local counterparts, such as the MOH, SSK, and universities, on activities within their areas of expertise, including training, social marketing, and management information system (MIS).

Table 1**Program Objectives and Subobjectives**

	Policy	Quality	Access
Objectives	Strengthen policy and GOT budgetary support for the family planning program.	Improve the quality of FP/RH services in the public and private sectors.	Expand access to FP/RH services and information in the public and private sectors.
Subobjectives	Increased support for FP within the GOT.	High-quality services and information available through the public and private sectors.	FP services expanded in existing public and private service delivery channels.
	Increased private sector involvement in FP programs.	FP training reoriented to emphasize quality of care.	Postpartum and postabortion services established in public and private sector.
	Strengthened NGO structures assuming more important roles.	IEC efforts focused on resolving specific problem areas as identified in surveys and program evaluations.	FP services directed to underserved groups.

A midterm assessment of the CAs' performance and their overall impact on program objectives is needed to determine whether the program is on course or requires some midcourse corrections.

1.3 Assessment Scope of Work

The purpose of this assessment is to review program achievement of the objectives set out in the 1995 to 1999 strategy. Following are the major issues and questions described in the Scope of Work (SOW):

- To what extent has the program accomplished the goals set out in the 1995 to 1999 strategic plan?

- Has the program met the benchmarks?
- If not, what are the impediments?
- How do the activities (subprojects) implemented by the CAs lead toward accomplishing these goals?
 - How appropriate are the activities implemented by the CAs?
 - How have these activities led to accomplishing the strategy?
 - Are there areas of duplication of effort among the CAs? Gaps?
 - How well are the financial and sustainability components integrated into three main components?
 - How effective is program coordination? How could it be strengthened?
 - In sum, are the right CAs doing the right things?
- Is there a need for midcourse corrections to the strategy?
 - Is there a need to revise the benchmarks and targets?
 - Are the indicators relevant? Is there a need to revise them?
- What are the needs and directions for future USAID assistance beyond 1999?

1.4 Methodology

1.4.1 Schedule and Approach

At USAID's request, the Population Technical Assistance Project (POPTECH) assembled a four-person, interdisciplinary team to conduct the five-week assessment. The team spent one week in Washington, D.C., meeting with USAID and CA headquarters staff, preparing an assessment plan, and reviewing documents. The team spent the last three weeks of October in Turkey meeting with embassy and local CA staff; reviewing documents; and making site visits in Ankara, Istanbul, Adana, Diyarbakır, and Eskisehir. Two brainstorming meetings were held with local CA representatives to discuss priorities and options. The team spent most of the third week preparing a draft report and discussing preliminary findings and recommendations with the CAs, MOH, and the Embassy staff. The team spent its final week in Washington, D.C. finalizing the report and debriefing USAID and CA headquarters staff.

1.4.2 Analytical Framework

The team used a two-part analytical framework. The first part of this framework focused on program achievements, organized according to the policy-quality-access framework described in Section 1.2. Chapter 2 discusses the achievement of the objectives outlined in the Strategic Plan. The second part, discussed in Chapter 3, assesses the achievements of each CA as defined in their annual workplans. Although these two parts are interrelated, both are necessary because the CAs tended to work on several subobjectives. Table 2 summarizes the subobjectives and CA activities.

Table 2

Annual Program Objectives and Lead Cooperating Agencies

Objective	AVSC	FPMD	JHPIEGO	PCS	Policy	SEATS	SOMARC
Policy							
Government support	L	L		Lc	L	L	c
Private sector support					Lc		
NGO support		Lc		c	Lc		
Quality							
Modern contraceptives	Lc					L	Lc
Training	Lc		Lc	L		Lc	Lc
IEC*	Lc		c	Lc		c	c
Access							
Quality services/IEC	Lc					c	Lc
Postpartum/abortion	Lc			L		c	Lc
Underserved groups	L						
Total as L/c	7/5	2/1	1/2	4/3	3/2	3/4	4/6

L=lead CA; c = collaborating CA

*PCS coordinates the IEC activities of all CAs

2. PROGRAM ACHIEVEMENTS

2.1 Goal Achievement: Health, Fertility, and Population Growth

As noted, the overall goals of the program are to (1) improve women's health, (2) reduce fertility, and (3) reduce population growth. Unfortunately, the team had no current data to assess achievements along these indicators. The 1998 Turkish Demographic and Health Survey (TDHS) will provide the data needed to make these assessments. In the meantime, Turkish experts believe that the results will be positive. According to informal estimates by the Institute of Population Studies at Hacettepe University, the total fertility rate (TFR) will decline from 2.7 in 1993 to between 2.3 and 2.4 in 1998. The population growth rate will drop from 1.6 in 1993 to 1.4 in the 1995 to 2000 period. Contraceptive prevalence will probably increase from 63 percent in 1993, but experts are unable to estimate the new 1998 level. Similarly, an unpredictable increase in use of modern FP methods is expected.

With regard to the SOW question on indicators, the team noted that there is no indicator in the plan for women's health and that none of the goals are quantified. Only one contraceptive prevalence objective is quantified—use of modern methods is to reach 45 percent—and only one discontinuation objective is quantified—discontinuation rate of oral contraceptives is to be reduced to 30 percent. The abortion reduction objective is not quantified, nor are there private sector objectives for modern methods, IUDs, voluntary sterilization (VS), and injectables. Knowledge of modern contraceptives was 98.6 percent in 1993 and the strategy includes an objective to increase that knowledge. However, the objective may be to increase knowledge of certain characteristics of modern methods, such as possible side effects. If so, an indicator needs to be established and quantified. Intermediate objectives have not been set for new acceptors or continuing users.

2.2 Achievement of Program Objectives

The program has made some progress on both of the objectives: (1) to increase the availability and effective use of quality family planning and reproductive health services and (2) to improve self-reliance in family planning and reproductive health by enhancing the public and private sector's ability to meet consumer demand without USAID support. The following sections summarize the program's progress in the three emphasis areas: policy, quality, and access.

2.2.1 Policy Support for the Family Planning Program

The program's policy objective was to increase support for family planning and reproductive health from the governmental (MOH and SSK), private, and NGO sectors. The program has made significant progress in the public and quasi-public sectors. An implementation plan is almost completed for the National Women's Health and Family Planning Strategy (NWH/FP). Both the MOH and SSK have obtained government funding for contraceptives. The MOH operates under a different system, but has successfully lobbied for contraceptive funding.

In the private sector, the Social Marketing for Change project (SOMARC) set up a network of providers in Istanbul (KAPS) and demonstrated that it is possible to recruit private hospitals, polyclinics, and physicians to provide family planning and reproductive health services. However, with 45 service sites, this network is small, expensive, and unlikely to be sustained in its current form or replicated elsewhere. Nevertheless, this model contains elements that could be used to develop and test an alternative approach.

Also in the private sector, an NGO network made up of approximately 20 large NGOs was set up and is now functioning as an advocacy group for women's health, education, and rights. This network is still in its infancy and needs guidance and technical assistance, especially to identify priority issues such as family planning and reproductive health, operationalize these issues into specific activities, work with local NGOs, and promote sustainability.

2.2.2 Access to Family Planning Services and Contraceptives

With regard to the access component, the objectives were to increase access to family planning and reproductive health services and contraceptives in the private and public sectors, to increase access to postpartum and postabortion (PA/PP) services, and to increase access for underserved populations.

In the public sector, some family planning and reproductive health services are available theoretically in most MOH facilities—275 MCH/FP centers, 5,300 health centers, and 11,800 health houses. In February 1996, the MOH changed its regulations to permit all methods including TL and NSV to be provided in its MCH/FP centers. A further change allowed nurse-midwives to provide DMPA injections. Services are not universally available due to lack of staff, equipment, or contraceptives. Out of 116 hospitals and 389 dispensaries, approximately 50 SSK facilities now provide family planning and reproductive health services as a direct result of USAID assistance. Some progress has been made in expanding access to a variety of methods, as well. Voluntary sterilization is now available in 20 provinces; Depo-Provera (DMPA) is offered at 100 sites in 8 provinces. In addition, IUDs, oral contraceptives, and condoms are generally available at most sites that provide family planning services. NORPLANT® has been introduced in a small number of sites but will not be continued due to cost.

In the private sector, the only service expansion activity was KAPS. Private sector provision of contraceptives has been very successful with respect to oral contraceptive pills and condoms, 75

percent of which come from the private sector. Voluntary sterilization services were introduced in KAPS's network but are not expected to expand rapidly. Two new contraceptives are about to be launched in the private sector—Depo-Provera and the Copper T (CuT) 300A IUD. Both are expected to increase access significantly.

The Turkey program was also expected to expand postpartum and postabortion services throughout Turkey and to increase available quality family planning services in urban areas and in the Southeast. Such activities have been introduced in several facilities in urban slum areas and several sites in the Southeast with promising results. A special postabortion and postpartum initiative is expected to be launched soon and should result in a replicable model that could be installed in most hospitals and polyclinics.

2.2.3 Quality of Family Planning and Reproductive Health Services, Training, and Information, Education, and Communication

With regard to the quality component, the program has concentrated on improving services and information, family planning training, and information, education, and communication (IEC) materials for providers and clients. The team's findings are generally consistent with those of the 1994 Situation Analysis, which found that in the public sector, at least in the USAID-assisted sites, improvements have been noted in providers' technical skills, infection prevention practices, counseling and client-provider communication, and awareness of principles of total quality management. However, evidence indicates that family planning services are still provider driven rather than client driven. Provider bias in favor of IUDs rather than hormonal methods—orals and injectables—is still widespread and reflects a lack of knowledge and understanding of contraceptive technology. Improvements are still needed in counseling, as many clients lack in-depth knowledge of contraceptive methods. In addition, more attention needs to be given not only to counseling training, but to on-the-job training and supervision to improve provider knowledge and communication skills. Furthermore, interventions are needed to increase consumer awareness of reproductive health, client rights, and quality of care (QOC).

A number of interventions to improve quality have been incorporated into KAPS's private provider network. These interventions include provider training programs in contraceptive technology, counseling, total quality management, quality customer service, clinical skills development, and infection prevention, as well as monitoring, excellence awards, development and distribution of various IEC materials, and a 24-hour "hot line." The impact of these interventions has not yet been assessed; however, client satisfaction surveys are scheduled to be undertaken this year. If feasible, an assessment of provider adherence to quality of care practices should be conducted at the same time.

The program has made significant improvement in clinical training. The development and dissemination of national family planning service guidelines; the development of a standardized, competency-based curriculum; and the establishment of a training system have all been major

accomplishments. However, application of these resources has been concentrated on a small proportion of medical school interns rather than on the midwives, obstetrics/gynecology (OB/GYN) specialists, and others who provide family planning services.

With regard to IEC, over the years the program has developed a large amount of high-quality IEC materials for providers and clients. These materials have not been widely disseminated, and when they are disseminated they are not always used. Given the continuing problems with provider bias and clients' lack of knowledge of modern methods, this failure to widely disseminate materials needs to be addressed. Efforts seem to be hindered to a large degree by the lack of a single IEC unit to coordinate and manage family planning and reproductive health IEC.

Conclusions

In general, the program has met some of its self-reliance objectives. The MOH, SSK, NGOs, and the private sector have increased in support. In addition, the private sector is making a major contribution to contraceptive self-reliance, which should take some pressure off the MOH in particular, and allow it to lobby for a contraceptive budget large enough to serve the poor and high-risk groups. However, neither sector has made sufficient progress in assuring the self-reliance of family planning and reproductive health services.

The project has made some progress in expanding access to and quality of family planning and reproductive health services and contraceptives in both the public, quasi-public, and private sectors. However, more work remains to ensure access to high-quality, comprehensive family planning and reproductive health services and permanent, long-term contraceptive methods in all appropriate facilities.

In summary, the team's broad conclusions are as follows:

1. Progress has been made in many areas. Many elements of the program have been developed and tested, but these elements are fragmented, limited in geographic scope, and not sufficiently integrated to achieve the desired impact.
2. Some elements of the program are sustainable, some are not; for others, sustainability has not yet been considered.
3. Some elements are replicable, some are not; for others, replicability is not even being considered.
4. Some performance indicators have been developed and are appropriate, but there are gaps, many indicators are not quantified, and some key intermediate indicators are missing. In many cases, no data is being collected to measure performance.

Recommendations

1. Over the next two years, USAID, the CAs, and Turkish counterparts in the public and private sectors need to focus on the larger picture. The key question they should be asking is, "What can we do to make a lasting impact on family planning and reproductive health services and, in turn through those services, women's health, fertility, and population growth?"
2. Greater interaction and more integration of program elements is needed to achieve national impact. Workplans should include quantified, annual performance indicators at the intermediate level (e.g., suggested postabortion and postpartum intervention).
3. All major interventions, especially any new ones, should build in sustainability strategies from the outset.
4. All major interventions should be designed to be replicable on as wide a scale as possible.
5. Performance indicators need to be quantified and expanded to include more intermediate indicators such as new acceptors and active users. Procedures need to be developed to collect, analyze, and report data on these indicators.
6. Research and evaluation are needed to assess needs (e.g., for clinical training and IEC materials) and to determine whether key interventions (e.g., clinical training and postabortion services) are having the desired impact.
7. An assessment of provider adherence to quality of care practices should be included in the assessment of KAPS's activities this year.

3. COOPERATING AGENCY PERFORMANCE

3.1 Introduction

Six CAs are currently working on the Turkey program. Each was selected for its expertise in a given area and has been assigned a general role within the program:

- **Policy Analysis, Planning, and Action project (POLICY):** Public policy issues
- **Social Marketing for Change project (SOMARC):** Private sector inv
- **Family Planning Management Development project (FPMD):**
Management strengthening, especially MIS
- **Johns Hopkins University/Population Communication Services project (JHU/PCS):** IEC materials and coordination
- **AVSC International:** Clinical services and training
- **Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO):** Clinical training

Although a local coordination mechanism exists (see Chapter 4) and the CA representatives get along well, CAs do not work as a team on a common set of tasks. Rather, each CA usually works independently on its own activities. In most cases, these activities cut across program objectives (see Table 2 in Chapter 1); however, there are exceptions to this rule. For example, SOMARC and AVSC collaborated on provider network surveys; SOMARC conducted a physician survey and AVSC conducted site assessments. These two CAs also collaborated on voluntary sterilization training for KAPS's providers. SOMARC identified and recruited the teams and AVSC provided the clinical training. Even in this type of collaboration, the individual CAs tend to work independently on separate and distinct portions of the larger activity. However, when they are collaborating, the CAs seem to work well together, especially in the field.

It is also important to note that the CAs have been working for different lengths of time on their activities; the number, type, and level of effort required vary; some CAs' activities have changed over time; and CAs do not have complete control over assigned activities. Their activities are negotiated with the JPT and summarized in annual workplans. The following assessments of individual CA performances are based on those workplans. The major activities of each CA are listed with results, conclusions, and recommendations.

3.2 The POLICY Project

POLICY's role in USAID's Turkey program is to strengthen policy support for family planning and reproductive health activities in the public, NGO, and private sectors. Policy has made notable achievements in all three sectors. Table 3 summarizes POLICY's objectives, outputs, and impact.

Table 3

POLICY Activities		
Objectives	Outputs	Impact
Increased political, financial, and programmatic support for FP/RH within the GOT, specifically: development of national strategy; contraceptive self-sufficiency; and improved targeting capability.	NWH/FP Strategy developed; follow-on implementation plan being finalized; MOH planning to purchase own contraceptives; strengthened planning/targeting capability in MOH.	Measurable impact on GOT support for FP/RH already occurred. In long term, these actions will have greater and more pervasive impact on strengthening support for FP/RH.
Strengthen NGO structures and role in advocacy.	KIDOG NGO network established. TA provided in fundraising, issues identification, networking, and advocacy techniques.	Increased NGO awareness of their political power when acting together. Future impact on FP/RH could be substantial if KIDOG develops as hoped.
Increased private sector involvement in FP/RH.	Gained endorsement of Turkish Medical Association, Turkish Pharmacists' Association, and identified private sector service provider leaders for future collaboration.	Difficult to estimate at this stage, but certainly impact will be in desired direction, i.e., increased involvement and support by private sector.

3.2.1 National Plan

Development of the National Women's Health and Family Planning Strategy and its implementation plan has been a long and grueling process due to the imperative of gaining the participation and support of a wide variety of groups. The process has involved numerous working group meetings with key ministries, NGOs, and the private and commercial sector to

draft, edit, and ratify the strategy and the plan. The strategy itself consists of a very long list of concerns and suggested avenues for action; it is hoped that the implementation plan will be far more selective in settling on fewer prioritized actions. The target date for final approval of the implementation plan is early 1998. POLICY plans by April 1998 to develop a monitoring and evaluation component for the implementation plan.

3.2.2 Contraceptive Self-Reliance

POLICY has concentrated on helping the MOH to target available resources and develop contraceptive self-sufficiency, and these efforts appear to be paying off. The MOH has received tenders for its first procurement of contraceptives and has planned and budgeted for future contraceptive procurement in 1998—oral contraceptives, IUDs, and condoms. The MOH has preliminary approval to procure, for the first time, 4.4 million condoms and 100,000 cycles of oral contraceptives. This is a significant first-time procurement, but is still behind schedule in terms of the phase-over plan. The overall distribution of responsibility for contraceptive "market share" is shown in Table 4.

Table 4

Expected Source Distribution for Family Planning Methods (Percent)

Year	Sector	Family Planning Method							
		IUD	Condom	OC	TL	Vasectomy	Injectables	NOR-PLANT	Other Modern
1997	Public	70.9	28.7	24.2	83.4	96.0	40.0	80.0	3.7
	Private	28.1	66.2	75.2	15.5	1.0	60.0	20.0	96.3
	Other	1.0	5.1	0.5	1.1	3.0	0.0	0.0	0.0
2000	Public	70.9	19.5	10.2	83.4	96.0	5.0	5.0	3.7
	Private	28.1	75.0	85.2	15.5	1.0	95.0	95.0	96.3
	Other	1.0	5.5	5.0	1.1	3.0	-	-	-

Source: National Strategy for Women's Health and Family Planning (p.16)

In addition to undertaking a market segmentation analysis to attempt to identify target groups for maternal child health and family planning services, POLICY recently introduced an easy-to-use, spreadsheet-based modeling tool to assist in forecasting future contraceptive needs and costs according to several policy and targeting options. This tool allows the MCH/FP General Directorate (GD) to examine the impacts of different policy alternatives, such as limiting free services to certain groups by class or geography. Several persons in the GD, including the general director himself, are quite computer-literate and should be able to make good use of this tool. In using this tool, an interesting early finding was that couples who were insured through SSK but were actually served in MOH facilities accounted for some 60 percent of the cost of family planning commodities within the MOH. Many were condom clients (in higher proportion than other MOH clients), and condoms are the most expensive budget item. See Figure 1.

3.2.3 Market Segmentation

POLICY has expended considerable effort to help the MOH analyze the overall contraceptive market structure and attempt to identify possible market segments to target services. POLICY's market segmentation process in Turkey is designed as a multistage continuum, from analysis to decision making to development of practical strategies for implementing those decisions. POLICY has completed the first stage—the market segmentation analysis—and is in the process of working with the MOH on the second stage, the decision-making stage. This stage requires further analysis and policy dialogue to assist the MOH in making decisions about how best to target its increasingly limited resources. POLICY intends to complete stage 2 by early spring 1998 and to move on to stage 3, identifying actions and developing procedures needed to implement the targeting strategy adopted.

Although the team believes POLICY's work is interesting and helpful to the MOH in examining its service options, there is some doubt as to the practical application of market segmentation results. In other countries, it has not been easy to selectively target income groups, insured or uninsured groups, or other identifiable groups in a practical way. Such devices as means tests, health cards, separate channels (green for those who don't pay, red for those who do) have not proved effective.

Therefore, focus should shift from developing additional segmentation scenarios to identifying practical ways to provide family planning services to each segment. In particular, focus should shift to identifying how the MOH can limit services to high-risk, underserved groups and how those who can afford to pay for private services can be directed to private providers. If reasonable mechanisms can be identified, such mechanisms should then be tested in small-scale operations research projects before being introduced nationally.

Figure 1

APPENDIX B

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